Continuity of Care Advisory Panel
Economic Workgroup Meeting Minutes
August 16, 2013

Prepared by Erin McMullen

Attendees:

1. Dr. Stephen Goldberg (Chair)
2. Erin McMullen (DHMH staff)
3. Suzanne Harrison
4. Adrienne Ellis
5. Scott Greene
6. NaToya Mitchell
7. Steve Daviss
8. Ryan Shannahan
9. Charles Gross
10. Bob Wells
11. Kait Roe
12. Jane Plapinger
13. Derrick Richardson
14. Mary Mastrandrea

I. Introductions

II. Approval of Minutes (8/19/2013)
   a. Minutes from the 8/19/2013 meeting of the workgroup were approved. There was one change to the minutes to correct for some misspelling.

III. Timeline
   a. The group must present its findings to the full Advisory Panel on September 4, 2013.
   b. A draft outline will be presented by the August 23, 2013 meeting. Dr. Goldberg and DHMH staff will work on the draft outline prior to the meeting.
      i. The report will discuss economic barriers from the perspective of:
         1. Consumers;
         2. Providers; and
         3. System issues.
      ii. Scott Greene indicated that the report should be broken up into sections based on different populations, such as the privately insured, the Medicaid population, and individuals eligible for health insurance through the exchange.
   c. By August 30, 2013 the workgroup shall have finalized recommendations and identified issues for future study.

d. The workgroup debated setting up a google group to function as a message board to discuss documents and data that the workgroup will be reviewing. DHMH staff is discussing this option with the Attorney General's office to ensure that this does not violate the Open Meetings Act.

IV. Update on Value Options Data request and questions from first meeting

a. DHMH staff provided an update on the workgroup's data request for Value Options. The data workgroup met on 08/15/2013 and they are beginning to pull data together. The data group is meeting again on 08/19/2013 and the Economic Workgroup should be given an estimated delivery time on the data request.
b. Suzanne Harrison asked the group what types of issues will the group be addressing in its final report.
    i. Should there be an emphasis on population health?
    ii. There are many entry points to the public mental health system. For instance, individuals can enter through the emergency room, or the correctional system. Are diagnostic categories a barrier to continuity of care?
c. Medication
    i. Steve Daviss noted every payor has different rules about medication, such as what is on their formulary. This affects continuity of care when an individual's insurance changes. Grandfathering and preferred drug lists may only be available on the payor end. Information from previous payors are unavailable. Some people are required to jump through extra hoops to remain on medications that they have been taking.
        1. While Medicaid has a four-month look back, private insurers do not have this type of ability. Is there an appeals process with private insurers? This could be a potential problem as individuals move between the Medicaid and connection.
d. Health Information Exchange (HIE)
    i. Steve Daviss indicated that limitations around the HIE need to be addressed for the inclusion of behavioral health entities. Maine and Rhode Island are good states to model after.
        1. Dr. Goldberg asked whether the legal group should examine whether patient consent rules need to be altered to remove barriers to continuity of care.
    ii. Mary Mastrandrea noted that there is an economic barrier that prevents providers from sharing information. This disrupts continuity of care. Managing the differences between payors, moving from paper to electronic systems, and communication between electronic systems is problematic. Two barriers need to be removed:
        1. The ability to establish an electronic health records (EHR) systems; and
        2. EHR compatibility (the HIE eliminates problems surrounding EHR compatibility).

iii. Excluding mental health providers from the HIE presents a barrier to continuity of care. The HIE would need to do additional legal work to include mental health providers. The cost of not including providers adversely impacts the system by perpetuating discontinuity. A recommendation needs to be made so that mental health providers can be included in the HIE. Steve Daviss said he would follow up with the Maryland Health Care Commission to see how much it would cost. Costs would depend on the number of mental health providers in Maryland.
    1. Suzanne Harrison asked what the costs were by not including mental health providers in the HIE.
        a. Dr. Goldberg noted that part of the problem is who is incurring the cost. The cost is to the system, not the individual provider. Others argued that it does hurt the provider.

iv. Is there a way to incentivize EHR utilization?
    1. Pay for performace is a good way to incentivize this. However, is that something that should be overseen by an ASO? The group noted that this depends on the payor source.
    2. Since federal law does not include behavioral health entities, does Maryland want to provide an incentive for providers who are not eligible for federal pay for performance?

e. Financial Costs to Consumers
    i. Kait Roe noted that financial costs for the patient should be included in the outline. This should be a separate subcategory within each section. Financial costs for the patient include whether an individual can afford transportation to and from their appointment, co-pays, and the cost of medication. These issues may seem like minor issues to payors, but they are big issues for consumers.
        1. It was noted that pharmacies may not deny an individual their medication if they can't afford a copay. However, this is not what occurs in practice. The workgroup should consider making a recommendation that requires all pharmacists to receive education on this issue.
            a. How do we work with private payors to ensure that patients have recourse when they are denied medications off of the preferred drug list?
        2. Instances when a consumer winds up in the emergency room after a denial of medications needs to be address.
    ii. Dr. Goldberg suggested that payors need to accommodate for these financial issues. Instead of having a consumer account for cost of copays, transportation, etc., the payor should adjust for this. This may be difficult to accomplish, and it should be limited to consumers with serious mental illness, or if a consumer is over utilizing the emergency room. There should be potential financial consequences for the payor if these issues are not addressed.
        1. The group agreed that we need more tools to assist high-end users.

iii. A recent New York Times article discussed the topic of copays and how they can interfere in patient outcomes.
iv. People also can't afford to take off work to go to their appointments. Steve Daviss noted that this is where telemedicine could play an important role.

f. Telemedicine
   i. Adrienne Ellis noted that telemedicine could also address the provider shortage.
   ii. Dr. Goldberg stated that far-end vs. near-end compensation must be addressed. Both ends need to be reimbursed for this to be a viable system.
   iii. Dr. Goldberg indicated that there are liability issues regarding telemedicine that produce economic consequences for providers.
   iv. Mary Mastrandrea reminded the group that technology is not a substitute for good clinical judgement. Providers are already communicating with consumers via email and other non-traditional methods without being compensated.

g. How do we create another access point to mental health services?
   i. Improving health literacy is necessary. Materials on how to navigate the public mental health system are available; however there are differences among the six regions within the Maryland Health Connection.
   ii. Dr. Goldberg suggested that a 311 system could be created for when individuals are having difficulties accessing care system-wide. This could reduce ER visits, and identify problem pharmacies and providers.
      1. Steve Daviss mentioned that this idea came up a number of years ago. It was suggested a sticker would be placed on the back of a consumer's medical assistance card. This idea was never implemented.

V. Discussion Topics

a. Inpatient diagnoses data and HSCRC readmissions data
   i. Steve Daviss presented data regarding the top 25 diagnostic codes. The chart he provided the group with displays the medical risk related to inpatient admissions.
      1. For individuals without mental health or substance abuse issues, there risk is given a score of 1.
      2. For those with mental health issues, there risk score is 2 to 4 times higher.
      3. Individuals with a substance abuse issue have a risk that is 7 times higher.
      4. For those with co-occurring mental health and substance abuse issues, the risk is 8 to 15 times higher.
   ii. Costs associated with these inpatient admissions are $86 million for fiscal 2011. While all of these costs cannot be eliminated, for individuals with comorbidities, adherence to treatment, and ensuring continuity of care, can reduce hospitalization costs.
   iii. These charts demonstrate why somatic costs should be included.
   iv. Steve Daviss noted he would provide studies for how costs for individuals with comorbidities can be reduced. He noted that savings are generally greater with

those with mild to moderate conditions, rather than those with serious mental illness.

b. Parity
    i. Adrienne Ellis explained the federal Mental Health Parity law to the group. She indicated that the law isn't full enforced because there are barriers to enforcing the law with private payors. It was noted that if the law was enforced, it would eliminate barriers to care.
        1. One example that was discussed surrounded proprietary issues regarding network adequacy standards. Parity applies to how payors ensure provider panels are adequate.
            a. However, there is no transparency around how adequacy is determined. The Mental Health Association of Maryland requested this criterion from a certain carrier; however it is considered proprietary. The Mental Health Association's request was denied.
        2. Other examples of this include how a payor determines whether care is medically necessary. However, payors refuse to share their medical criteria.
        3. Dr. Goldberg suggested that a recommendation should be made to the legal workgroup in regards to these examples. Certain information shouldn't be proprietary.
    ii. Kait Roe indicated that provider networks are inadequate. It was asked whether there is any legal responsibility to ensure that providers listed are actually accepting new patients. The group stated that there was no legal responsibility. The following issues were raised:
        1. There are no penalties to payors when provider directories are inaccurate. There should be incentives for accurate directories.
        2. Transparency should be increased. If claims data was linked to directories consumers could see whether providers were accepting new patients.
        3. Directories should allow patients to update web directories to indicate whether there is availability for new patients. This could be incorporated using a thumbs up/thumbs down icon.
    iii. The question was raised as to whether the group should recommend that parity be fully enforced in Maryland.
        1. Adrienne Ellis mentioned that there are proprietary issues regarding network adequacy standards.

VI. Future Topics for Discussion – Outpatient Civil Commitment

a. DHMH staff noted that at the workgroup's August 23, 2013 meeting, we will be discussing outpatient civil commitment. Three articles will be sent to workgroup members to review prior to the next meeting. The articles focus on outcomes in New York State and it was requested that if anyone was aware of data from other states that they share it with the group and staff.

i. Steve Daviss and Mary Mastrandrea indicated that they would look for data on outcomes in Pennsylvania.

b. Dr. Goldberg noted that we should produce two arguments:
    i. Does outpatient civil commitment improve the system; or
    ii. Do we need to improve access to services?
c. Dr. Goldberg also asked the group to consider whether the State should look at improving immediate access to services, and then look at outpatient civil commitment.
d. Kait asked the group whether outpatient civil commitment is cost shifting and if we are criminalizing behavior?
e. Dr. Goldberg explained that there is a shortage of inpatient psychiatric beds and that people wind up in the emergency room because psychiatric beds aren't available. He believes that this occurs because psychiatric beds are being improperly used. If forensic competency evaluations were handled in the criminal justice system, this would free up psychiatric beds.
    i. It was noted that it takes several months for an individual to receive a competency evaluation. They must wait in the criminal justice system, and then they receive an assessment in an outpatient setting. If a recommendation is made for inpatient hospitalization, an individual gets put on a waitlist for the hospital. Once they are admitted, restoration can take two to six months before people are adjudicated as competent. The bottleneck for this group of individuals needs to be removed. There is no way to get someone help, unless there is a charge against them. Consequently, individuals wind up in correctional facilities because they can't get help within the mental health system.
    ii. In Arizona, this process is being conducted in the prison setting.
    iii. Dr. Goldberg informed the group that in the 1960's the Supreme Court ruled that a hospital is more restrictive than a jail. Dr. Goldberg asked the group whether they were aware of this ruling and asked for their feedback on their understanding of the impact it may have on what can/should be done in a correctional setting vs. a hospital setting.
        1. Kait Roe indicated that jail is more restrictive than hospitals; however individuals are in jail for a set timeframe with the option of parole. In comparison, individuals that are declared incompetent in a hospital setting have no recourse and no set timeline for hospitalization.

VII. Adjourn